

## MARGIN RESERVED FOR BINDING

V. S. No. 1.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

## 1 PLACE OF DEATH

County Kent 15711  
120

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 204Village or City Tolchester (No. )

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Elizabeth Bassall

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED <u>Single</u> (Write the word)
---------------------	--------------------------------	--

## 6 DATE OF BIRTH

unknows (Month) 1853 (Year)

## 7 AGE

60 yrs. — mos. — ds.

If LESS than  
1 day. hrs.  
OR min.?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work

House work

(b) General nature of industry business, or establishment in which employed (or employer)

## 9 BIRTHPLACE

(State or country)

Md

## PARENTS

## 10 NAME OF FATHER

P. E. Bassall

## 11 BIRTH PLACE OF FATHER

(State or country)

Md

## 12 MAIDEN NAME OF MOTHER

Jones

## 13 BIRTHPLACE OF MOTHER

(State or country)

Md

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE :

(Informant)

Eos. Bassall

(Address)

Tolchester P. O.

## 15

Filed Sept-16 1918 by J. W. Smith

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Sept 14, 1918  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 8, 1918, to Sept 14, 1918, that I last saw her alive on Sept 13, 1918, and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH was as follows:

Chronic nephritis(Duration) 1 yrs. 0 mos. 0 ds.Contributory  
Secondary

(Signed) H. J. Summers, M. D.  
Sept 16, 1918 (Address) Charlottesville

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place  
of death            yrs.            mos.            ds.  
Where was disease contracted,  
if not at place of death?

In the  
State,            yrs.            mos.            ds.  
Former or  
usual residence           

## 19 PLACE OF BURIAL OR REMOVAL

Ains House DATE OF BURIAL  
Sept 16, 1918

## 20 UNDERTAKER

H. W. Hicks ADDRESS  
Charlottesville

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer in Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housenmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia", unqualified, is indefinite); *Tuberculosis of lungs*, *mени-*

*ges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasm(s); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intervening) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc., "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OR INJURY and qualify as ACCIDENTAL, SUICIDAL, OR HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scpsis*, *lungs*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

OCT 4 1915

BUTTERAVILLE

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

<b>1 PLACE OF DEATH</b>		15712	STATE OF MARYLAND CERTIFICATE OF DEATH		
County	Kent	(No.)	Registration Dist. No. 200		
Village or City	Galena	(No.)	St.	Ward)	(15)
<b>2 FULL NAME</b> <i>Anna Lindell Beaston</i>					
<b>PERSONAL AND STATISTICAL PARTICULARS</b>					
<b>3 SEX</b>	<b>4 COLOR OR RACE</b>	<b>5 SINGLE, MARRIED, WIDOWED, OR DIVORCED</b>	<b>SINGLE</b>		
<i>M.</i>	<i>Wh.</i>	<i>Single</i>			
<b>6 DATE OF BIRTH</b>					
<i>Sept 7</i>			<i>1915</i>		
(Month) (Day) (Year)					
<b>7 AGE</b>					
yrs.	mos.	ds.	It LESS than 1 day, hrs. OR min.?		
<i>100</i>	<i>21</i>	<i>0</i>			
<b>8 OCCUPATION</b>					
(a) Trade, profession, or particular kind of work.					
<i>nine</i>					
(b) General nature of industry, business, or establishment in which employed (or employer)					
<i>md.</i>					
<b>9 BIRTHPLACE (State or country)</b>					
<i>md.</i>					
<b>10 NAME OF FATHER</b>					
<i>A. Lindell Beaston</i>					
<b>11 BIRTHPLACE OF FATHER (State or country)</b>					
<i>md.</i>					
<b>12 MAIDEN NAME OF MOTHER</b>					
<i>Anna Buckworth</i>					
<b>13 BIRTHPLACE OF MOTHER (State or country)</b>					
<i>md.</i>					
<b>14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE</b>					
(Informant) <i>Geo. T. Jones</i>					
(Address) <i>Galena Md.</i>					
<b>15</b>					
Filed <i>Sept 29, 1915</i>			Geo. T. Jones Local REGISTRAR		
If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.					
<b>16 DATE OF DEATH</b>					
<i>Sept 28</i>			<i>1915</i>		
(Month) (Day) (Year)					
<b>17 I HEREBY CERTIFY, That I attended deceased from</b>					
<i>Sept 7</i>			<i>Sept 28</i>		
1915, to <i>Sept 28</i> , 1915			1915		
that I last saw him alive on <i>Sept 28</i> , 1915					
and that death occurred on the date stated above, at <i>72</i> m.					
The CAUSE OF DEATH* was as follows:					
<i>Influenza</i>					
(Duration) yrs. mos. ds.					
<b>Contributory (Secondary)</b>					
<i>Geo. T. Jones</i>					
(Duration) yrs. mos. ds.					
(Signed) <i>Geo. T. Jones</i> , M. D.					
Sept 28, 1915 (Address) <i>Galena Md.</i>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
<b>18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)</b>					
At place of death yrs. mos. ds. In the State yrs. mos. ds.					
Where was disease contracted, if not at place of death?					
Former or usual residence.					
<b>19 PLACE OF BURIAL OR REMOVAL</b>					
<i>Bethel Cemetery, City Co.</i>			DATE OF BURIAL <i>Sept 29, 1915</i>		
<b>20 UNDERTAKER</b> <i>Father</i>					
ADDRESS <i>Galena Md.</i>					

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

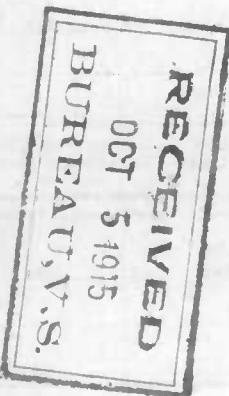
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Saxsman*, (b) *Grocer*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc. *Carcin-*oma. *Sarcoma*, etc., of \_\_\_\_\_ (name origin: "Can-*cer*" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-gential," "Senile," etc.), "Dropsey," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Maras-mus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL sepi-*tis*," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

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## 1 PLACE OF DEATH

15713

County Kent

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registered No. 201

Village or City Kennedyville No. 78

St. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Wester Ann Bennett

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

W.

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

widow

## 6 DATE OF BIRTH

Feb 1, 1841  
(Month) (Day) (Year)

## 7 AGE

74 yrs. 7 mos. 24 ds. If LESS than  
1 day, hrs.  
OR min. ?

## 8 OCCUPATION

 (a) Trade, profession, or  
particular kind of work(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

At Home

## 9 BIRTHPLACE

(State or country)

Delaware

## 10 NAME OF FATHER

Joseph Davis

## 11 BIRTHPLACE OF FATHER

(State or country)

Delaware

## 12 MAIDEN NAME OF MOTHER

Margret Roache

## 13 BIRTHPLACE OF MOTHER

(State or country)

Maryland

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

F. S. Caine

(Address)

Kennedyville

## 15

Filed Sept 26, 1915 William Pross  
Seal REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Sep 25, 1915

(Month)

(Day)

(Year)

## 17

I HEREBY CERTIFY, That I attended deceased from

July 1915 to Sep 25, 1915  
that I last saw her alive on Sep 25, 1915

and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis  
of Stomach

(Duration) 1 yrs. 8 mos. 0 ds.

Contributory (Secondary) Tuberculosis of Stomach

(Duration) yrs. 0 mos. 0 ds.

(Signed) J. W. Urie M. D.

(Address) Sep 26, 1915 Kennedyville Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

Milford Del Sept 28, 1915

## 20 UNDERTAKER

W. H. Krouse Still Pond

## DATE OF BURIAL

ADDRESS

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the DISEASE causing DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonacum*, etc.. *Carcin-*oma. *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Gan-  
cer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Malaria," "Old Age," "Shock," "Tetraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture or skull, and consequences (e. g., *scarsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## MARGIN RESERVED FOR BINDING

V. S. No. 1.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Kent

15714

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 202

Village or City near Laurel

(No.) Chestertown

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Florence Lillian Black

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Col

5 SINGLE,  
MARRIED,  
WIDOWED  
OR DIVORCED  
(Write the word)

married

6 DATE OF BIRTH

Dec. 24, 1892  
(Month) (Day) (Year)

7 AGE

22 yrs. 8 mos. 9 ds.

If LESS than  
1 day, hrs.  
OR min.?

8 OCCUPATION

(a) Trade, profession, or  
particular kind of work

Cook

(b) General nature of industry  
business, or establishment in  
which employed (or employer)

9 BIRTHPLACE

(State or country)

Kent Co Md

## PARENTS

10 NAME OF FATHER

Ferry Black

11 BIRTHPLACE OF FATHER  
(State or country)

Kent Co Md

12 MAIDEN NAME OF MOTHER

Hannah Bowers

13 BIRTHPLACE OF MOTHER  
(State or country)

Kent Co.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Julius Wailey

(Address)

Norton, Md

15

Filed Sept. 4, 1915 - W. L. Hicks  
Local REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept 2, 1915  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from  
Sept. 1, 1915, to Sept. 1, 1915,  
that I last saw her alive on Sept. 1, 1915,  
and that death occurred on the date stated above, at 3:30 A.M.

The CAUSE OF DEATH \* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Burial) yrs. mos. ds.

(Signed) Francisco Lynch, M. D.  
Sept. 3, 1915 (Address) Chestertown\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT  
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,  
SUICIDAL or HOMICIDAL.18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)At place  
at death yrs. moe. ds.Where was disease contracted,  
if not at place of death?Former or  
usual residence19 PLACE OF BURIAL OR REMOVAL  
Road Neck Kent Co Md Sept 4<sup>th</sup>, 191520 UNDERTAKER Chas. L. Dodd  
ADDRESS Chestertown

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*; *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Collon mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer in Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *mени-*

ges, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Col-lapse," "Coma," "Convulsions," "Debility," ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uracmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and QUALITY as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as PROBABLY such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

OCT 5 1915

BUREAU, U. S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH Kent County 15715

Village or City Rock Hall (No.)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 203

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME Julia Christiana Blackiston

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female	4 COLOR OR RACE White	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widow
--------------	-----------------------	--

## 6 DATE OF BIRTH

Dec 25, 1845  
(Month) (Day) (Year)

## 7 AGE

69 yrs. 9 mos. 5 ds. If LESS than  
1 day, hrs.  
OR min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work. At Home  
(b) General nature of industry, business, or establishment in which employed (or employer) Merchandise

9 BIRTHPLACE  
(State or country)

Kent Co. Md

## 10 NAME OF FATHER

George T. Tracy

11 BIRTHPLACE OF FATHER  
(State or country)

Maryland

## 12 MAIDEN NAME OF MOTHER

Mary Sims

13 BIRTHPLACE OF MOTHER  
(State or country)

Maryland

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Columbus Blackiston  
(Address) Rock Hall Md

15 Filed 10/2 1913-7B, Dunderig  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 30, 1913  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 1st, 1913, to Sept 30, 1913,

that I last saw her alive on Sept 28, 1913,

and that death occurred on the date stated above, at 12:30 p.m.

The CAUSE OF DEATH\* was as follows:

Cancer of Rectum  
Exhaustion  
(Duration) yrs. mos. ds.

Contributory  
Secondary

(Signed) Walter O. Kelly, M. D.  
Oct 1, 1913 (Address) Rock Hall Md

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Wesley Chapel Cemetery Oct 2, 1913  
DATE OF BURIAL

20 UNDERTAKER Thos H. Casey & Co., Rock Hall ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Houskeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhold pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum, etc.*, *Carcinoma*, *Sarcoma*, etc. of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Anemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sensus, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED	NOV 1 1915
BURTON	

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

## PLACE OF DEATH

15716

County KentVillage or City Galena (No. ....)STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 200

St. .... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Hester E. Butters

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)
---------------------	--------------------------------	--

## 6 DATE OF BIRTH

Sept 5, 1867  
(Month) (Day) (Year)

## 7 AGE

48 yrs. 0 mos. 24 ds. 11 LESS than  
1 day, hrs.  
OR min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country)

## 10 NAME OF FATHER

11 BIRTHPLACE OF FATHER  
(State or country)

## 12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER  
(State or country)

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed Oct. 21, 1915 Geo. J. Davis  
L. L. REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

9 30, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

June 1<sup>st</sup>, 1915, to Sept. 30, 1915,  
that I last saw h. e. alive on Sept. 30, 1915,

and that death occurred on the date stated above, at 7 P.M.,

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis(Duration) 3 yrs. 6 mos. ds.Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Oct. 1<sup>st</sup>, 1915 (Address) D.W. Latimer M. D.

\* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the \_\_\_\_\_ State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted,  
if not at place of death?Former or  
usual residence

## 19 PLACE OF BURIAL OR REMOVAL

Davis Hill Md Oct. 2, 1915 DATE OF BURIAL

## 20 UNDERTAKER

W.T. Sticks ADDRESS Glastonbury

# REVISED UNITED STATES STANDARD

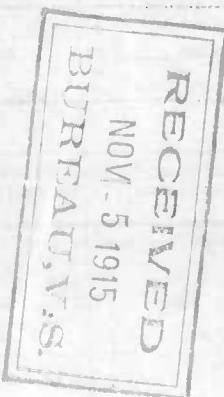
## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc.. *Carcin-*oma, *Sarcoma*, etc. of \_\_\_\_\_ (name origin); "Can-  
cer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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**WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD**

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<b>1 PLACE OF DEATH</b>		15717	STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Kent</u>		Registration Dist. No. <u>201</u>		
Village or City <u>Dutchtown</u> (No.)		St.: <u>Ward</u> )		
<u>15</u>				
<b>2 FULL NAME</b> <u>Roger R Colvinton</u>				
<b>PERSONAL AND STATISTICAL PARTICULARS</b>				
<b>3 SEX</b> <u>male</u>	<b>4 COLOR OR RACE</b> <u>Black</u>	<b>5 SINGLE, MARRIED, WIDOWED, OR DIVORCED</b> (Write the word) <u>single</u>	<b>16 DATE OF DEATH</b> <u>Sept. 18</u> , 1915 (Month) (Day) (Year)	
<b>6 DATE OF BIRTH</b> <u>July 21</u> , 1915 (Month) (Day) (Year)		<b>17 I HEREBY CERTIFY</b> That I attended deceased from <u>Medical Attention</u> , 1915, that I last saw him alive on <u>Attention</u> , 1915, and that death occurred on the date stated above, at <u>2 P.M.</u> The CAUSE OF DEATH* was as follows:		
<b>7 AGE</b> <u> yrs. — mos. 26 ds.</u>		<b>18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)</b> <u>Premature Birth</u> (Duration) <u>8</u> yrs. <u>8</u> mos. <u>0</u> ds.		
<b>8 OCCUPATION</b> (a) Trade, profession, or particular kind of work <u>Household</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Kent Co Md</u>		<b>Contributory (Secondary)</b> <u>Frank W. Smith, Physician</u> , M.D. (Signed) <u>Sept 18, 1915</u> (Address) <u>Chesapeake</u>		
<b>9 PARENTS</b>	<b>10 NAME OF FATHER</b> <u>Howard Colvinton</u>		<b>11 BIRTHPLACE OF FATHER</b> (State or country) <u>Kent Co</u>	
	<b>12 MAIDEN NAME OF MOTHER</b> <u>Mary E. Bratcher</u>		<b>13 BIRTHPLACE OF MOTHER</b> (State or country) <u>Kent Co Md</u>	
<b>14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE</b> (Informant) <u>Robert Bratcher</u> (Address) <u>Still Pond</u>				
<b>15 Filed</b> <u>Sep 18, 1915</u> <b>Registrar</b> <u>Dellian Parr</u> Local REGISTRAR				
<b>16 PLACE OF BURIAL OR REMOVAL</b> <u>Still Pond</u> <b>DATE OF BURIAL</b> <u>Sept 19, 1915</u>				
<b>17 UNDERTAKER</b> <u>W. H. Kruzen</u> <b>ADDRESS</b> <u>Still Pond</u>				
If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. B. No. 1.				

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Associated]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer*—Coal mining, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc. *Carcin-*oma. *Sarcoma*, etc. of ..... (name origin); "Cap-  
ter" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Dehility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)  
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## 1. PLACE OF DEATH

Kent

15718

County

Village or City

Wilmington (No.)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 202

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2. FULL NAME

Rachel M Cooper

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE,  
MARRIED,  
WIDOWED  
OR DIVORCED  
(Write the word)

6. DATE OF BIRTH

April 8, 1915  
(Month) (Day) (Year)

7. AGE

yrs. 5 mos. 7 ds.

If LESS than  
1 day, hrs.  
OR min.?

## 8. OCCUPATION

(a) Trade, profession, or  
particular kind of work(b) General nature of industry  
business, or establishment in  
which employed (or employer)

## 9. BIRTHPLACE

(State or country)

## PARENTS

10. NAME OF  
FATHER11. BIRTHPLACE  
OF FATHER  
(State or country)12. MAIDEN NAME  
OF MOTHER13. BIRTHPLACE  
OF MOTHER  
(State or country)

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed Sept. 16, 1915 - Mrs. Hicks

Local REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Sep 14, 1915  
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from  
Sept. 12, 1915, to Sept. 14, 1915,  
that I last saw her alive on Sept. 14, 1915,  
and that death occurred on the date stated above, at 9 a.m.  
The CAUSE OF DEATH \* was as follows:

Cholera Infantum

(Duration) yrs. mos. 2. ds.

Contributory  
Secondary(Signed) Harry L. Dodd, M. O.  
Sept. 16, 1915 (Address) Chestertown, Md.\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT  
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,  
SUICIDAL or HOMICIDAL.18. LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)At place  
of death yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or  
usual residenceIn the  
State, yrs. mos. ds.

## 19. PLACE OF BURIAL OR REMOVAL

Chestertown, Md. Sept. 16, 1915 (Date of Burial)

## 20. UNDERTAKER

Chas L. Dodd, Chestertown (Address)

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary Foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intermittent) affection need not be stated unless indicated. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Col-lapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mareasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "Puerperal septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scrosis*, *telanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

**RECEIVED**

OCT. 5 1915

BUREAU U.S.

## MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County..... Kent

15719

(No.)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 202

Village or City..... Chestertown

(No. ...., St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME..... Abram S. Crawford.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

White

5 SINGLE,  
MARRIED,  
WIDOWED  
OR DIVORCEDMarried  
(Write the word)

## 6 DATE OF BIRTH

Sept 24, 1854

(Month)

(Day)

(Year)

## 7 AGE

60 yrs. 11 mos. 12 ds.

If LESS than  
1 day, hrs.  
OR min.?

## 6 OCCUPATION

(a) Trade, profession, or  
particular kind of work(b) General nature of industry  
business, or establishment in  
which employed (or employer)

## 8 BIRTHPLACE

(State or country)

## PARENTS

## 10 NAME OF FATHER

Benj. M. Crawford

## 11 BIRTHPLACE OF FATHER

(State or country)

## 12 MAIDEN NAME OF MOTHER

Alice Hodice

## 13 BIRTHPLACE OF MOTHER

(State or country)

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed Sept 6, 1915 - W. S. Sticks

Local REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Sept 11, 1915

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from  
Mar 10, 1915, to Sept 4, 1915,that I last saw him alive on Sept 4, 1915,  
and that death occurred on the date stated above, at 11 m.

The CAUSE OF DEATH \* was as follows:

Cancer of stomach

(Duration) yrs. 6 mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) Sept 5, 1915 (Address) H. G. Simpers, M. D.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted,  
if not at place of death?Former or  
usual residence

## 19 PLACE OF BURIAL OR REMOVAL

Chestertown Md Sept 6, 1915

DATE OF BURIAL

## 20 UNDERTAKER

Thomas L. Dodd Chestertown

ADDRESS

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

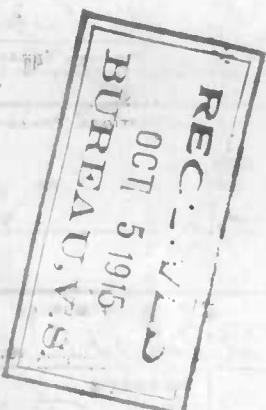
[Approved by U. S. Census and American Public Health Association.]

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, menin-*

ges, peritonaeum, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mumps*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intervening) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

**1 PLACE OF DEATH**  
County Kent 15720

Village or City Rock Hall (No.)

**2 FULL NAME** Eliza Herrickson

## PERSONAL AND STATISTICAL PARTICULARS

<b>3 SEX</b>	<b>4 COLOR OR RACE</b>	<b>5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)</b>
Female	White	Widowed

**6 DATE OF BIRTH**  
May 15, 1830  
(Month) (Day) (Year)

**7 AGE**  
85 yrs. 4 mos. 11 ds. If LESS than  
1 day, hrs. OR min. ?

**8 OCCUPATION**  
(a) Trade, profession, or particular kind of work  
At home  
(b) General nature of industry, business, or establishment in which employed (or employer)

**9 BIRTHPLACE**  
(State or country) Pennsylvania

**10 NAME OF FATHER**  
John P. Smith.

**11 BIRTHPLACE OF FATHER**  
(State or country) Pennsylvania

**12 MAIDEN NAME OF MOTHER**  
Leah Lichtenwalner

**13 BIRTHPLACE OF MOTHER**  
(State or country) Pennsylvania

**14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) John Edward Hadaway  
(Address) Rock Hall, Md

15 Filed 9/29 1913 T. B. Durding

REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 203

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## MEDICAL CERTIFICATE OF DEATH

**16 DATE OF DEATH** Sept. 27, 1915  
(Month) (Day) (Year)

**17** I HEREBY CERTIFY, That I attended deceased from Anger, 1915, to Sept. 27, 1915, that I last saw her alive on Sept. 26, 1915,

and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH\* was as follows:

General debility  
Exhaustion  
(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.  
(Signed) Walter J. Seay, M.D.  
Sept. 27, 1915 (Address) Rock Hall, Md.

\* State the DISEASE CAUSING DEATH, or, In deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

**18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)**

At place of death yrs. mos. ds. In the State yrs. mos. ds

Where was disease contracted, if not at place of death?

Former or usual residence

**19 PLACE OF BURIAL OR REMOVAL** Saint Paul's Cemetery **DATE OF BURIAL** Sept. 29, 1915

**20 UNDERTAKER** Thos. H. Cassey **ADDRESS** Rock Hall

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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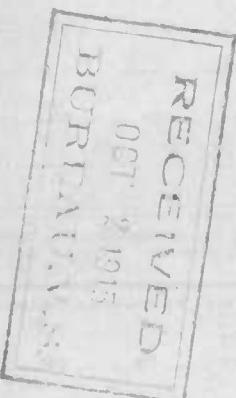
**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum, etc.*, *Carcin-*

oma

"

oma, *Sarcoma*, etc. of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Masculitis*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.s.; *Bronchopneumonia* (secondary), 10 d.s. Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Dehility" ("Congestual," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

**1 PLACE OF DEATH**

County Kent

15721

**STATE OF MARYLAND  
CERTIFICATE OF DEATH**

Registration Dist. No. ....

St. .... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City Newtown (No. 1)

**2 FULL NAME**

Mary E. Dickerson

**PERSONAL AND STATISTICAL PARTICULARS**

<b>3 SEX</b>	<b>4 COLOR OR RACE</b>	<b>5 SINGLE, MARRIED, WIDOWED, OR DIVORCED</b>
Female	Black	Single (Write the word)

**6 DATE OF BIRTH**  
Oct 23, 1910  
(Month) (Day) (Year)

**7 AGE**  
4 yrs. 10 mos. 25 ds.  
It LESS than  
1 day, \_\_\_\_ hrs.  
OR \_\_\_\_ min. ?

**8 OCCUPATION**

- (a) Trade, profession, or particular kind of work
- (b) General nature of industry, business, or establishment in which employed (or employer)

**9 BIRTHPLACE  
(State or country)**

**10 NAME OF  
FATHER**

**11 BIRTHPLACE  
OF FATHER  
(State or country)**

**12 MAIDEN NAME  
OF MOTHER**

**13 BIRTHPLACE  
OF MOTHER  
(State or country)**

**14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) Alfred Dickerson

(Address) Worton Md

**15**

Filed Sept 78, 1915 William Davis  
Local REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16 DATE OF DEATH**  
Sept 8th, 1915  
(Month) (Day) (Year)

**17 I HEREBY CERTIFY, That I attended deceased from**  
Sept 8th, 1915, to Sept 18, 1915,  
that I last saw her alive on Sept 17, 1915,  
and that death occurred on the date stated above, at 1:30 A.M..  
The CAUSE OF DEATH\* was as follows:

(Duration) yrs. mos. ds.  
**Contributory  
(Secondary)** Typhoid Fever.

(Duration) yrs. mos. ds.  
(Signed) L. P. Alvill, M. D.  
Sept 18, 1915. (Address) Still Pond.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

**18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)**

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,  
if not at place of death?

Former or usual residence

**19 PLACE OF BURIAL OR REMOVAL**

Coleman

**20 UNDERTAKER**

W. F. Hansen

**DATE OF BURIAL**

Sept 19, 1915

**ADDRESS**

Still Pond

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

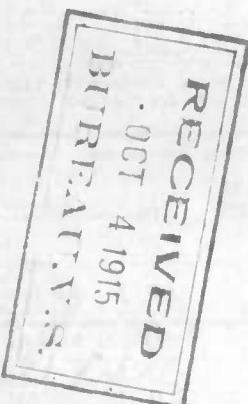
Statement of occupation—Precise statement of occupation is very important, so that the relative zenithfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement. It should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

## Statement of cause of death—Name, first, the disease

causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum*, etc.; *Carcin-*

*oma*, *Sarcoma*, etc., of ..... (name origin: "Cap-  
sular neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Dehility" ("Con genital," "Senile," etc.), "Dropsey," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railroad train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH County <u>Kent</u>		15722	(28)
Village or City <u>Still Pond</u> (No.)		St. _____ Ward _____	
2 FULL NAME <u>Mary Virginia Hard</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Female</u>	4 COLOR OR RACE <u>Black</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)	
6 STATE OF BIRTH <u>Unknown</u>		(Month) (Day) (Year)	
7 AGE <u>About 62</u>	yr. mos. ds.	If LESS than 1 day, hrs. OR min. ?	
8 OCCUPATION <u>Housewife</u>		(Duration) yrs. mos. ds.	
<input checked="" type="checkbox"/> (a) Trade, profession, or particular kind of work. <input type="checkbox"/> (b) General nature of industry, business, or establishment in which employed (or employer)		Contributory Secondary	
9 BIRTHPLACE (State or country) <u>Kent Co Md</u>		Tuberculosis	
10 NAME OF FATHER <u>Wm Gillison</u>		(Duration) unkonw mos. ds.	
11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>		(Signed) <u>L. P. Atwood</u> , M. D.	
12 MAIDEN NAME OF MOTHER <u>Eliza Henry</u>		Sept. 3, 1915 (Address) <u>Still Pond</u>	
13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>		*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.	
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE			
(Informant) <u>Geo May Jr</u>		At place of death yrs. mos. ds. In the State yrs. mos. ds.	
(Address) <u>Still Pond</u>		Where was disease contracted, if not at place of death?	
15 Filed <u>9-3-1915</u> William Pass.		Former or usual residence.	
		16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)	
		17 DATE OF BURIAL	
		18 PLACE OF BURIAL OR REMOVAL <u>Still Pond</u>	
		19 DATE OF BURIAL <u>Sept. 5, 1915</u>	
		20 UNDERTAKER <u>W. J. Hansen</u>	
		ADDRESS <u>Still Pond</u>	

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 201

MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>Aug 20</u>		(Month) <u>Aug</u> (Day) <u>20</u> (Year) <u>1915</u>	
17 I HEREBY CERTIFY, That I attended deceased from <u>Aug 20</u> , 1915, to <u>Sept 2</u> , 1915,			
that I last saw him alive on <u>Aug 20</u> , 1915,			
and that death occurred on the date stated above, at <u>11.45 P.M.</u>			
The CAUSE OF DEATH* was as follows:			
<u>Heart Failure</u>			
Contributory Secondary		Tuberculosis	
(Duration) unkonw mos. ds.		(Signed) <u>L. P. Atwood</u> , M. D.	
Sept. 3, 1915 (Address) <u>Still Pond</u>		*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.	
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)			
At place of death yrs. mos. ds. In the State yrs. mos. ds.			
Where was disease contracted, if not at place of death?			
Former or usual residence.			
19 PLACE OF BURIAL OR REMOVAL <u>Still Pond</u>		DATE OF BURIAL <u>Sept. 5, 1915</u>	
20 UNDERTAKER <u>W. J. Hansen</u>		ADDRESS <u>Still Pond</u>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Houseworker*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meningitis*, *peritonitis*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*TUERPEAL septicaemia*," "*TUERPEAL peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

OCT 4 1915

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

**1 PLACE OF DEATH**  
 County Kent 15728  
 Village or City near Gelt (No.)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 200

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Margaret P. George**2 FULL NAME**

## PERSONAL AND STATISTICAL PARTICULARS

<b>3 SEX</b>	<b>4 COLOR OR RACE</b>	<b>5 SINGLE, MARRIED, WIDOWED, OR DIVORCED</b> (Write the word)
Female	White	Widow

**6 DATE OF BIRTH**  
Mar. 22, 1835  
 (Month) (Day) (Year)

**7 AGE**  
80 yrs. 5 mos. 13 ds. If LESS than  
 1 day, hrs.  
 OR min.?

**8 OCCUPATION**

(a) Trade, profession, or particular kind of work Housenip  
 (b) General nature of industry, business, or establishment in which employed (or employer)

**9 BIRTHPLACE**  
(State or country)

**10 NAME OF FATHER**  
Peter Babby

**11 BIRTHPLACE OF FATHER**  
(State or country) Switzerland

**12 MAIDEN NAME OF MOTHER**  
Unknown

**13 BIRTHPLACE OF MOTHER**  
(State or country) Switzerland

**14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**  
 (Informant) Edw George

(Address) Fourteenth Del Rd.

**15**  
 Filed 9/5 1915 Harry Griffith  
 (Signature) REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

12P

## MEDICAL CERTIFICATE OF DEATH

**16 DATE OF DEATH** Sept 3rd, 1915  
 (Month) (Day) (Year)

**17 I HEREBY CERTIFY, That I attended deceased from**  
July 13, 1915, to Sept 3, 1915,  
 that I last saw her alive on Sept 2, 1915,  
 and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH\* was as follows:

Chronic Intestinal Neuritis

**Contributory (Secondary)** Exhaustion  
 (Duration) yrs. mos. ds.

(Signed) J. Herbert Bates, M. D.  
 9/4 1915 (Address) Mellington Md.  
 (Duration) yrs. mos. ds.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

**18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)**

At place \_\_\_\_\_ yrs. mos. ds. In the \_\_\_\_\_  
 of death \_\_\_\_\_ yrs. mos. ds. State \_\_\_\_\_ yrs. mos. ds.

Where was disease contracted,  
 if not at place of death?

Former or  
 usual residence \_\_\_\_\_

**19 PLACE OF BURIAL OR REMOVAL**

**20 UNDERTAKER** Lompson Cemetery DATE OF BURIAL  
9/6 1915  
 ADDRESS Tansende

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as Day laborer, Farm laborer, Laborer—Contractor, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children, not gainfully employed, as At school or At home. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as Servant, Cook, Housemaid, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: Farmer (retired 6 yrs.). For persons who have no occupation whatever, write None.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebrospinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Group"); Typhoid fever (never report "Typhoid pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritonaeum, etc. Cancer-

oma, Sarcoma, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: Measles (disease causing death), 29 d.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mastitis," "Old Age," "Shock," "Rickets," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "TRUERBAL septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED	OCT. 5 1915
BUREAU, U.S.	

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
Kent County

15724

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 200

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City Millington (No.)

2 FULL NAME  
*Mary Gibbs*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female	4 COLOR OR RACE Colored	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married
-----------------	----------------------------	---

6 DATE OF BIRTH  
Unknown  
(Month) (Day) (Year)

7 AGE  
47 yrs. mos. ds.  
If LESS than  
1 day, hrs.  
OR min. ?

## 8 OCCUPATION

- (a) Trade, profession, or particular kind of work Housewife
- (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country)

Md.

## 10 NAME OF FATHER

Jos. Massey

Md.

## 11 BIRTHPLACE OF FATHER

(State or country)

## 12 MAIDEN NAME OF MOTHER

Jane Berry

Md.

## 13 BIRTHPLACE OF MOTHER

(State or country)

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

15

Filed: 9-16-1915 Earl A. Stafford  
Deputy REGISTRAR

If more blanks are needed, address State Regis trar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH  
Sept 13, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That attended deceased from Feb. 1915, to Sept 13, 1915

that I last saw her alive on Sept 12, 1915

and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH\* was as follows:

*Cerebral Apoplexy*

Contributory (Secondary) Chronic Intoxication  
(Duration) yrs. 6 mos. ds.

Replete (Duration) 1 yrs. mos. ds.

(Signed) Herbert Ballo, M.D.  
9/14/1915 (Address) Millington Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

Millington Md. Collected 16, 1915

## 20 UNDERTAKER

John Schmidt Millington  
Md.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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(a) Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children, not gainfully employed, as At school or At home. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as Servant, Cook, Housemaid, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: Farmer (retired 6 yrs.). For persons who have no occupation whatever, write None.

**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebrospinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritonacum, etc. Carcin-

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cer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Ast-  
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genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Maras-  
mus," "Old Age," "Shock," "Traëma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "UTERINE septica-  
mia," "UTERINE peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; Struck by railway train—accident; Revolver round of had—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

OCT 5 1915

BUREAU OF

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County *Key*

15725

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 24

Village or City *Sandy Bottom*

(No.)

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

*Rosie May Gilbert*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDDED  
OR DIVORCED  
(Write the word)

Female Col

Married

6 DATE OF BIRTH

May 15, 1877

(Month)

(Day)

(Year)

7 AGE

38 yrs. 4 mos. 24 ds.

It LESS than  
1 day, hrs.  
OR min.?

8 OCCUPATION

(a) Trade, profession, or  
particular kind of work(b) General nature of industry  
business, or establishment in  
which employed (or employer)

9 BIRTHPLACE

(State or country)

*Keed Co.*

## PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER

(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *James L. Gilbert*

(Address)

*Chesapeake*

15

Filed *Sept 15, 1915* For Small

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept. 1, 1916

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from

*Sept. 2, 1915, to Sept. 8, 1915,*  
that I last saw her alive on *Sept. 8, 1915,*and that death occurred on the date stated above, at *10 A.M.*

The CAUSE OF DEATH \* was as follows:

*Acute Nephritis*

(Duration) yrs. mos. ds.

Contributory

Secondary

*Frail W. Wright*  
(Signed) *Frail W. Wright* yrs. mos. ds.  
*Sept. 15, 1915* (Address) *Chesapeake*, M. D.\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT  
CAUSE, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,  
SUICIDAL OR HOMICIDAL.18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted,  
if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

*Sunday Bottom Cemetery*

DATE OF BURIAL

*Sept. 10, 1915*

20 UNDERTAKER

ADDRESS

*Thos. H. Casey & Co., Rock Hall*

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia", unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*, *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intervening) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "A trophy," "Col-lapse," "Coma," "Convulsions," "Debility," ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Urticaria," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

OCT. 1 1915

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

## 1 PLACE OF DEATH

Kent County

15720

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. ....

Village or City

*Bayfield*(No. *Mellington*)

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 CITY DISTRICT

*2nd district*

2 FULL NAME

*Anna May Goodman*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female white

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED  
OR DIVORCED  
(Write the word)

single

6 DATE OF BIRTH

April 2, 1915

(Month) (Day) (Year)

7 AGE

Yrs. 5 mos. 7 ds.

If LESS than  
1 day, hrs.  
OR min.?

8 OCCUPATION

(a) Trade, profession, or  
particular kind of work(b) General nature of industry  
business, or establishment in  
which employed (or employer)

9 BIRTHPLACE

(State or country)

Kent Co. Md

10 NAME OF  
FATHER

Orville Goodman

11 BIRTHPLACE  
OF FATHER

(State or country)

Kent Co.

12 MAIDEN NAME  
OF MOTHER

Elsie Dickenson

13 BIRTHPLACE  
OF MOTHER

(State or country)

Kent Co.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Elsie Goodman

(Address)

Mellington.

15

Filed *Sept. 10<sup>th</sup>*, 1915William Parr  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept. 9, 1915

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from  
*No. Melrose*that I last saw h alive on *Attuction*, 1915,

and that death occurred on the date stated above, at 1 P. m.

The CAUSE OF DEATH \* was as follows:

*Intussusception*

(Duration) yrs. mos. 2 ds.

Contributory  
Secondary*Frankel Wright*  
(Signature) *Frankel Wright* (Address) *Chestertown*  
Sept. 10, 1915, M. D.\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT  
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,  
SUICIDAL or HOMICIDAL.18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)At place  
of death yrs. mos. ds. In the  
Where was disease contracted,  
if not at place of death? State, yrs. mos. ds.Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL

*Chestertown, Md* Sept. 10<sup>th</sup>, 1915

DATE OF BURIAL

20 UNDERTAKER

*James L. Dodd Chestertown*

ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

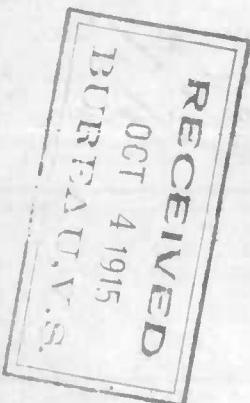
[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term in the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spirer*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer at coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Hauskeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia", unqualified, is indefinite); *Tuberculosis of lungs*, menin-

ges, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *lethargus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH Kent 15727  
 County Kent 150

Village or City Fairlee (No. Chestertown)

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 204

2 FULL NAME Eva Gross

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>Col.</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) <u>Single</u>
---------------------	-----------------------------	---

6 DATE OF BIRTH unknown

7 AGE <u>10</u>	IF LESS than 1 day, <u>hrs.</u> OR <u>min. ?</u>
YRS. .... MOS. .... DS. ....	

### 8 OCCUPATION

- (a) Trade, profession, or particular kind of work Picking Tomatoes
- (b) General nature of industry business, or establishment in which employed (or employer) Frank W. Smith

9 BIRTHPLACE  
(State or country) Kent Co. Md

10 NAME OF FATHER Benj. Gross

11 BIRTHPLACE OF FATHER  
(State or country) unknown

12 MAIDEN NAME OF MOTHER Marie Hynson

13 BIRTHPLACE OF MOTHER  
(State or country) Kent

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jerry Gross

(Address) Chestertown

15 FILED Sept 23, 1915

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept. 21

(Month) 1915 (Year)

17 I HEREBY CERTIFY, That I attended deceased from No. Medical, 1915,

that I last saw h. alive on Sept 21, 1915,

and that death occurred on the date stated above, at 6 P. m.

The CAUSE OF DEATH \* was as follows:

Septic Sore Throat - Neglect

Contributory Secondary (Duration) yrs. mss. 14 ds.

(Signed) Frank W. Smith (Address) Chestertown (Duration) yrs. mss. 4 ds.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT REBORNENTS)

At place In the  
of death yrs. mss. ds. In the  
Where was disease contracted, State, yrs. mss. ds.

If not at place of death?

Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL  
Chestertown Sept 23, 1915

20 UNDERTAKER

ADDRESS  
Louis L. Dodd, Chestertown

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Hausmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritoneum, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*, *Whooping cough*, *Chronic valvular heart disease*, *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Con-gential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*, *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

OCT 1 1915  
U.S. DEPT. OF COMMERCE

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <i>Baltimore</i>		15728
Village or City <i>Bettison</i>		(No.)
113		
2 FULL NAME <i>Mary Alice Fedges</i>		
PERSONAL AND STATISTICAL PARTICULARS		
3 SEX <i>Female</i>	4 COLOR OR RACE <i>White</i>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <i>widow</i>
6 DATE OF BIRTH <i>Aug 10, 1858</i> (Month) (Day) (Year)		
7 AGE <i>57 yrs. 1 mos. 19 ds.</i> IT LESS than 1 day, hrs. OR min.?		
8 OCCUPATION (a) Trade, profession, or particular kind of work <i>At Home</i> (b) General nature of industry, business, or establishment in which employed (or employer)		
9 BIRTHPLACE (State or country) <i>Maryland</i>		
10 NAME OF FATHER <i>Isaac Camper</i>		
11 BIRTHPLACE OF FATHER (State or country) <i>Maryland</i>		
12 MAIDEN NAME OF MOTHER <i>Matilda Smith</i>		
13 BIRTHPLACE OF MOTHER (State or country) <i>Maryland</i>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <i>Mrs Anna Greenwood</i> (Address) <i>Bettison Md</i>		
15 Filed <i>Sept 29<sup>th</sup>, 1915</i> by <i>William P. Davis</i> Local REGISTRAR		

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. I.

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *201*

St. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Sept 29, 1915*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *Aug 1st, 1915* to *Sept 1st, 1915*,  
that I last saw her alive on *Sept 1st, 1915*,  
and that death occurred on the date stated above, at *10 a.m.*.  
The CAUSE OF DEATH\* was as follows:

*Cirrhosis of the Liver.*

(Duration) yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *W. S. Maxwell*, M. D.  
*9-29-1915* (Address) *Still Pond, Md.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

*Still Pond* DATE OF BURIAL *Oct 1<sup>st</sup>, 1915*

20 UNDERTAKER *W. J. Johnson* ADDRESS *Still Pond*

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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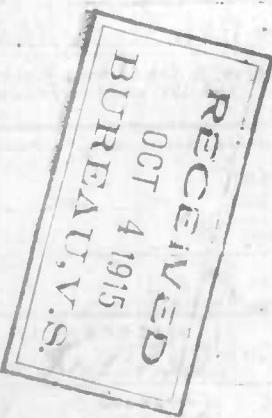
(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer*—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum*, etc. *Carcin-*

oma

"*Sarcoma*, etc., of (name origin); "*Ganglion*" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital"), "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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**1 PLACE OF DEATH**  
County *Kent* 15729  
*104*

Village or City *Sassapahs* (No.)

**2 FULL NAME**

*Esther C. Horner*

**STATE OF MARYLAND  
CERTIFICATE OF DEATH**

Registration Dist. No. *200*

St. \_\_\_\_\_ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

**PERSONAL AND STATISTICAL PARTICULARS**

<b>3 SEX</b> <i>Female</i>	<b>4 COLOR OR RACE</b> <i>White</i>	<b>5 SINGLE, MARRIED, WIDOWED, OR DIVORCED</b> <i>Infant</i> (Write the word)
-------------------------------	--	---

**DATE OF BIRTH**

*July 2, 1916*  
(Month) (Day) (Year)

<b>7 AGE</b> <i>Yrs. 3 mos. 5</i>	IT LESS THAN 1 day, ____ hrs. OR ____ min. ?
--------------------------------------	--

**8 OCCUPATION**

- (a) Trade, profession, or particular kind of work  
*Infant*
- (b) General nature of industry, business, or establishment in which employed (or employer)

**9 BIRTHPLACE  
(State or country)****10 NAME OF FATHER****11 BIRTHPLACE OF FATHER  
(State or country)****12 MAIDEN NAME OF MOTHER****13 BIRTHPLACE OF MOTHER  
(State or country)****14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant)

(Address)

**15**

Filed *Sept. 9, 1916* Harry Griffith

REGISTRAR

**MEDICAL CERTIFICATE OF DEATH****16 DATE OF DEATH**

*Sept. 7, 1916*  
(Month) (Day) (Year)

**17 I HEREBY CERTIFY, That I attended deceased from**  
*Sept. 7, 1916* to *Sept. 7, 1916*,  
that I last saw her alive on *Sept. 7, 1916*,  
and that death occurred on the date stated above, at *2 P.M.*

The CAUSE OF DEATH\* was as follows:

*Acute Enteritis*

(Duration) yrs. mos. 2 ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *L. M. Munro, M.D.*

*Sept. 7, 1916* (Address) *Baltimore, Md.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

**18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)**

At place of death yrs. mos. ds. to the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

**19 PLACE OF BURIAL OR REMOVAL**

*Sassapahs*

**20 UNDERTAKER**

*S. A. Collins Townsend Del*

**DATE OF BURIAL**

*Sept. 9, 1916*

**ADDRESS**

**REVISED UNITED STATES STANDARD  
CERTIFICATE OF DEATH**

[Approved by U. S. Census and American Public Health Association]

### Association.

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oma. Sarcoma, etc., of ..... (name origin: "Can-  
cer" is less definite; avoid use of "Tumor" for malig-  
nant neoplasms); Measles; Whooping cough; Chronic  
valvular heart disease; Chronic interstitial nephritis,  
etc. The contributory (secondary or intercurrent)  
affection need not be stated unless important. Ex-  
ample: Measles (disease causing death), 29 d.;   
Bronchopneumonia (secondary), 10 d.. Never report  
mere symptoms or terminal conditions, such as "As-  
thenia," "Anæmia" (merely symptomatic), "Atrophy,"  
"Collapse," "Coma," "Convulsions," "Debility" ("Con-  
genital," "Senile," etc.), "Dropsy," "Exhaustion,"  
"Heart failure," "Haemorrhage," "Inanition," "Mars-  
mus," "Old Age," "Shock," "Traenæma," "Weakness,"  
etc., when a definite disease can be ascertained as the  
cause. Always qualify all diseases resulting from  
childbirth or miscarriage, as "PUERPERAL septicæ-  
mia," "PUERPERAL peritonitis," etc. State cause for  
which surgical operation was undertaken. For vio-  
lent deaths state means of injury and quality as  
ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably  
such, if impossible to determine definitely. Examples:  
Accidental drowning; Struck by railway train—accid-  
ental; Revolver wound of head—homicide; Poisoned  
by carbolic acid—probably suicide. The nature of the  
injury, as fracture of skull, and consequences (e. g.,  
sepsis, tetanus) may be stated under the head of  
"Contributory." (Recommendations on statement of  
cause of death approved by Committee on Nomencla-  
ture of the American Medical Association.)

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*; *Carcin-*

RECEIVED

BUREAU, V.G

## MARGIN RESERVED FOR BINDING

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1 PLACE OF DEATH  
County..... Kent

15730

(64)

Village or City..... Rock Hall (No.)

2 FULL NAME William Jones

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male	4 COLOR OR RACE White	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Married
------------	-----------------------	---

6 DATE OF BIRTH

May 14, 1855  
(Month) (Day) (Year)

7 AGE

60 yrs. 3 mos. 21 ds.

If LESS than  
1 day. hrs.  
OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

farmer

9 BIRTHPLACE

(State or country)

Maryland

## PARENTS

10 NAME OF FATHER

William Jones

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Hannah Knox

13 BIRTHPLACE OF MOTHER

(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

William Jones

(Address)

Rock Hall

15

Filed 9/8, 1910 - J.B. Durdling

REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 203

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept. 5, 1910  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug 30, 1910, to Sept. 5, 1910, that I last saw him alive on Sept. 4, 1910, and that death occurred on the date stated above, at m. The CAUSE OF DEATH \* was as follows:

Cerebral Hemorrhage

(Duration) yrs. 5 mos. ds.

Contributory  
Secondary

Diseases - yrs. mos. ds.

(Signed) Frank W. Langley (Address) Chester Co., Md.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place  
of death yrs. mos. ds.Where was disease contracted,  
if not at place of death?Former or  
usual residenceIn the  
State, yrs. mos. ds.

19 PLACE OF BURIAL OR REMOVAL

Wesley Chapel Cemetery Sept. 8, 1910

DATE OF BURIAL

20 UNDERTAKER

Thos. H. Casey &amp; Son Rock Hall

ADDRESS

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

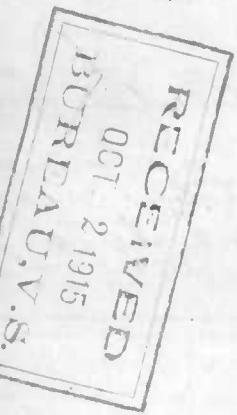
[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Slatemonger*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Form laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia", unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritonaeum, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*, *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or integrant) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*, *Struck by railway train—accident*, *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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## 1 PLACE OF DEATH

County *71 East.* 15731  
*Low  
Co*

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. \_\_\_\_\_

St.: Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City *Lacust Grove* (No. \_\_\_\_\_)

## 2 FULL NAME

*Merrin Claudelle Lynch*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>m.</i>	4 COLOR OR RACE <i>W.</i>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <i>Single</i>
-----------------	---------------------------	---

## 6 DATE OF BIRTH

*Dec. 27, 1914*  
(Month) (Day) (Year)

## 7 AGE

*8 yrs. 8 mos. 23 ds.*  
If LESS than  
1 day, hrs.  
OR min. ?

## 8 OCCUPATION

- (a) Trade, profession, or particular kind of work. *None*  
 (b) General nature of industry, business, or establishment in which employed (or employer) *None*

9 BIRTHPLACE  
(State or country)*Delaware.*

## 10 NAME OF FATHER

*Carl Lynch.*11 BIRTHPLACE OF FATHER  
(State or country)*Md.*

## 12 MAIDEN NAME OF MOTHER

*Ethel Chisfield*13 BIRTHPLACE OF MOTHER  
(State or country)*Md.*

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Paul Hernandez Paris*(Address) *Lacust Grove Md.*

## 15

Filed *Sept 20<sup>th</sup> 1915* *Delavan Parr*  
Local REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

*Sept 19, 1915*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *Sept 19, 1915*, to *Sept 19, 1915*,  
that I last saw him alive on *Sept. 19, 1915*,  
and that death occurred on the date stated above, at *49 m.*,  
The CAUSE OF DEATH\* was as follows:

*Cholera*  
*Influenza*

*7 D.B.* (Duration) yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *Geo. R. Jones, M.D.*  
*Sept 19, 1915* (Address) *Galam Md.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

## 19 PLACE OF BURIAL OR REMOVAL

*Chestertown* DATE OF BURIAL  
*Sept 21, 1915*

## 20 UNDERTAKER

*W. C. Grusen* ADDRESS  
*Still Pond.*

# REVISED UNITED STATES STANDARD

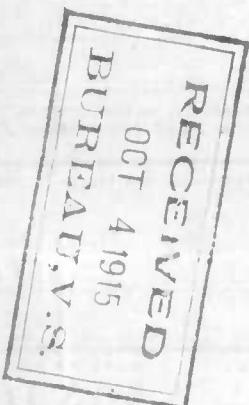
## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc. *Carcin-*  
*oma. Surcoma*, etc., of \_\_\_\_\_ (name origin); "Can-  
cer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)  
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**1 PLACE OF DEATH** Kent— 15732

County Kent

Village or City Georgetown

(No.) Morton

**2 FULL NAME** James Parker

**PERSONAL AND STATISTICAL PARTICULARS**

<b>3 SEX</b> Female	<b>4 COLOR OR RACE</b> Col	<b>5 SINGLE, MARRIED, WIDOWED OR DIVORCED</b> (Write the word) Single
<b>6 DATE OF BIRTH</b> April 19, 1915 (Month) (Day) (Year)		
<b>7 AGE</b> 5 yrs. 10 mds. 10 ds. If LESS than 1 day, hrs. OR min.?		

**8 OCCUPATION**  
 (a) Trade, profession, or  
particular kind of work \_\_\_\_\_  
 (b) General nature of industry  
business, or establishment in  
which employed (or employer) \_\_\_\_\_

**9 BIRTHPLACE**  
(State or country) Kent Co. Md

**10 NAME OF FATHER**  
Thomas Parker  
**11 BIRTHPLACE OF FATHER**  
(State or country) Calvert Co.

**12 MAIDEN NAME OF MOTHER**  
Liza Frantz  
**13 BIRTHPLACE OF MOTHER**  
(State or country) Kent Co. Md

**14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**  
(Informant) Liza Parker  
(Address) Morton

**15**  
Filed 9, 1915

REGISTRAR

**STATE OF MARYLAND  
CERTIFICATE OF DEATH**

Registration Dist. No. 204

St.; Ward)

[If death occurred in  
a hospital or institution,  
give its NAME instead  
of street and number.]

**MEDICAL CERTIFICATE OF DEATH**

**16 DATE OF DEATH** Sept. 29, 1915  
(Month) (Day) (Year)

**17** I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 1915, to \_\_\_\_\_, 1915, that I last saw h. alive on \_\_\_\_\_, and that death occurred on the date stated above, at 90 m. m.

The CAUSE OF DEATH \* was as follows:

Marasmus, from  
insufficient - suffic.  
Contributory, Malnutrition,

(Duration) yrs. 5 mcs. de.  
(Signed) J. Franklin Smith, M. D.  
Sept. 30, 1915. (Address) Chestertown

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

**18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)**

At place \_\_\_\_\_  
of death \_\_\_\_\_ yrs. \_\_\_\_\_ mcs. \_\_\_\_\_ de.

Where was disease contracted,  
if not at place of death? \_\_\_\_\_  
In the \_\_\_\_\_ State, \_\_\_\_\_ yrs. \_\_\_\_\_ mcs. \_\_\_\_\_ de.

Former or  
usual residence \_\_\_\_\_

**19 PLACE OF BURIAL OR REMOVAL** New Fairlee Kent Co. Md. **DATE OF BURIAL** Oct. 1, 1915

**20 UNDERTAKER** John W. Dadd **ADDRESS** Chestertown

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *mengo-*

ges, peritonaeum, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthma," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Renover wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

OCT 4 1915

BUREAU, U. S.

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**should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of**  
**OCCUPATION is very important. See instructions on back of certificate.**

**1 PLACE OF DEATH**  
 County *Kenly* 15733  
 Village or City *Near Lanesford* (No.)

**STATE OF MARYLAND**  
**CERTIFICATE OF DEATH**

Registration Dist. No. *204*

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

**2 FULL NAME** *Elizabeth Price***PERSONAL AND STATISTICAL PARTICULARS**

<b>3 SEX</b>	<b>4 COLOR OR RACE</b>	<b>5 SINGLE, MARRIED, WIDOWED OR DIVORCED</b> (Write the word)
<i>Female</i>	<i>White</i>	<i>widow</i>

**6 DATE OF BIRTH**  
*June 30, 1832*  
 (Month) (Day) (Year)

**7 AGE**  
*83 yrs. 2 mos. 16 ds.*  
 If LESS than  
 1 day, hrs.  
 OR min. ?

**8 OCCUPATION**  
 (a) Trade, profession, or particular kind of work  
*None*  
 (b) General nature of industry business, or establishment in which employed (or employer)  
*—*

**9 BIRTHPLACE**  
 (State or country) *Caroline Co Md*

**10 NAME OF FATHER**  
*Bullock*

**11 BIRTHPLACE OF FATHER**  
 (State or country) *Caroline Co Md*

**12 MAIDEN NAME OF MOTHER**  
*Muldown*

**13 BIRTHPLACE OF MOTHER**  
 (State or country) *Caroline Co Md*

**14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**  
 (Informant) *Mrs. Martha Walker*

(Address) *Chesterlown R D*

**15**  
 Filed *1911*

REGISTRAR

**MEDICAL CERTIFICATE OF DEATH****16 DATE OF DEATH***Sept 16, 1915*  
 (Month) (Day) (Year)

**17 I HEREBY CERTIFY, That I attended deceased from**  
*Sept 1, 1915, to Sept 16, 1915,*  
 that I last saw her alive on *Sept 11, 1915,*  
 and that death occurred on the date stated above, at *12 m.*

**The CAUSE OF DEATH \* was as follows:**

*Organic heart  
 Disease  
 Senile*  
 (Duration) yrs. mos. ds.  
 Contributory Secondary

**(Signed)** *Frank B. Jones*, M. D.  
 (Address) *Chesterlown Md*  
 (Date) *Sept 16, 1915*

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

**18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)**

At place of death yrs. mos. ds.  
 Where was disease contracted,  
 if not at place of death?

Former or usual residence

**19 PLACE OF BURIAL OR REMOVAL**

*Chesterlown*  
 (Date) *Sept 18, 1915*

**20 UNDERTAKER**

*Charles Dodd*  
 ADDRESS *Chesterlown*

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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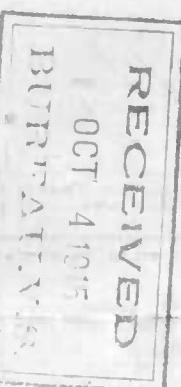
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*ges*, *peritonaeum*, etc.; *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*, *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intervening) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Dehility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uracnia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and QUALITY as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

OCT 4 1915



## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County..... Kent  
1573½

Village or City.... Millington (No.)

104  
2 FULL NAME.... Maggie Jane Price

PERSONAL AND STATISTICAL PARTICULARS		
3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
Female	white	single
6 DATE OF BIRTH		
	Dec 25	, 1913
	(Month)	(Day)
		(Year)
7 AGE	1 yrs. 8 mos. 21 ds.	If LESS than 1 day, .... hrs. OR min. ?

8 OCCUPATION	(a) Trade, profession, or particular kind of work.....
	(b) General nature of industry, business, or establishment in which employed (or employer).....

9 BIRTHPLACE (State or country)	Md.
------------------------------------	-----

10 NAME OF FATHER	Odie Price
-------------------	------------

11 BIRTHPLACE OF FATHER (State or country)	Md.
---	-----

12 MAIDEN NAME OF MOTHER	Maggie Moore
--------------------------	--------------

13 BIRTHPLACE OF MOTHER (State or country)	Md.
---	-----

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (informant)	Odie Price
(Address)	Millington Md

15	9-18-1915
Fried.	Earle A. Stafford

REGISTRAR
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If more blanks are needed, address State Regis trar, 6 E Franklin St., Balto., Requesting V. S. No. 1.

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 205

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 17, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 8, 1915, to Sept 17, 1915,  
that I last saw her alive on Sept 17, 1915,  
and that death occurred on the date stated above, at 12 noon.

The CAUSE OF DEATH\* was as follows:

Cholera Typhenterium

(Duration) yrs. mos. 10 ds.  
Contributory (Secondary) Exhauation

(Duration) yrs. mos. ds.  
(Signed) J. Herbert Baker, M. D.  
9/17, 1915 (Address) Millington Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the \_\_\_\_\_  
of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds

Where was disease contracted,  
if not at place of death?

Former or  
usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Millington Md DATE OF BURIAL 9 19, 1915

20 UNDERTAKER Robert Smith ADDRESS 1 Millington Md

## REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association]

— 1 —

**Statement of occupation—**Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause or death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*; *Carcin-*

**oma.** *Sarcoma, etc., of* \_\_\_\_\_ (name origin); "Can-  
cer" is less definite; avoid use of "Tumor" for malignant  
neoplasms); *Measles*; *Whooping cough*; *Chronic*  
*valvular heart disease*; *Chronic interstitial nephritis*,  
etc. The contributory (secondary or intercurrent)  
affection need not be stated unless important. Example:  
**Measles** (disease causing death), **29 ds.**  
**Bronchopneumonia** (secondary), **10 ds.** Never report  
mere symptoms or terminal conditions, such as "An-  
aemia," "Anaemia" (merely symptomatic), "Atrophy,"  
"Collapse," "Coma," "Convulsions," "Debility" ("Con-  
genital," "Senile," etc.), "Dropsy," "Exhaustion,"  
"Heart failure," "Haemorrhage," "Inanition," "Maras-  
mus," "Old Age," "Shock," "Taenia," "Weakness,"  
etc., when a definite disease can be ascertained as the  
cause. Always qualify all diseases resulting from  
childbirth or miscarriage, as "Puerperal septicema-  
tic," "Puerperal peritonitis," etc. State cause for  
which surgical operation was undertaken. For violent  
deaths state means of injury and quality as  
ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably*  
such, if impossible to determine definitely. Examples:  
**Accidental drowning;** *Struck by railway train—accident;*  
*Revolver wound of head—homicide;* *Poisoned*  
*by carbolic acid—probably suicide.* The nature of the  
injury, as fracture of skull, and consequences (e. g.,  
*sepsis, tetanus*) may be stated under the head of  
**"Contributory."** (Recommendations on statement of  
cause of death approved by Committee on Nomenclature  
of the American Medical Association.)

**oma.** *Sarcoma, etc., of* \_\_\_\_\_ (name origin); "Can-  
cer" is less definite; avoid use of "Tumor" for malignant  
neoplasms); *Measles*; *Whooping cough*; *Chronic*  
*valvular heart disease*; *Chronic interstitial nephritis*,  
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mus," "Old Age," "Shock," "Taenia," "Weakness,"  
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**Accidental drowning;** *Struck by railway train—accident;*  
*Revolver wound of head—homicide;* *Poisoned*  
*by carbolic acid—probably suicide.* The nature of the  
injury, as fracture of skull, and consequences (e. g.,  
*sepsis, tetanus*) may be stated under the head of  
**"Contributory."** (Recommendations on statement of  
cause of death approved by Committee on Nomenclature  
of the American Medical Association.)

## RECEIVER

OCT. 5 1915

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH Baltimore County		15735
Village or City Chesterstown		(No. 81) High St.; Ward)
2 FULL NAME Benjamin G. Russell		
PERSONAL AND STATISTICAL PARTICULARS		
3 SEX Female	4 COLOR OR RACE White	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) widow
6 DATE OF BIRTH Octo 26, 1840 (Month) (Day) (Year)		
7 AGE 74 yrs. 11 mos. 3 ds.	If LESS than 1 day, hrs. OR min. ?	
8 OCCUPATION (a) Trade, profession, or particular kind of work Housewife		
(b) General nature of Industry business, or establishment in which employed (or employer)		
9 BIRTHPLACE (State or country) Baltimore Md.		
10 NAME OF FATHER Wm. Frazer		
11 BIRTHPLACE OF FATHER (State or country) Baltimore Md.		
12 MAIDEN NAME OF MOTHER Elizabeth Nedee		
13 BIRTHPLACE OF MOTHER (State or country) Maryland		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Not the Russell (Address) Chesterstown Md.		
15 Filed Sept. 30, 1915 — W. W. Steele Local REGISTRAR		

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 202

[If death occurred in  
a hospital or institution,  
give its NAME instead  
of street and number.]

MEDICAL CERTIFICATE OF DEATH		
16 DATE OF DEATH Sept 29, 1915 (Month) (Day) (Year)		
17 I HEREBY CERTIFY, That I attended deceased from 1910, to Sept 29, 1915, that I last saw her alive on Sept 28, 1915, and that death occurred on the date stated above, at 3:30 p.m. The CAUSE OF DEATH is as follows: arteriosclerosis		
Duration yrs. mos. ds.		
Contributory Secondary		
J. H. Scampers, M. O. (Signed) Sept 29, 1915 (Address) Chesterstown		
* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.		
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. Where was disease contracted, if not at place of death? Former or usual residence		
19 PLACE OF BURIAL OR REMOVAL Chesterstown Md. Oct. 1st, 1915 DATE OF BURIAL		
20 UNDERTAKER Chas. L. Dodd, Chesterstown ADDRESS		

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

{Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*; and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, static occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges*, *peritonacum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Col-lapse," "Convulsions," "Debility" ("Con-genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Kent

15736

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 202

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City Chestertown (No.)2 FULL NAME Stephen Calvin Walker

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>married</u>
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6 DATE OF BIRTH

June 26, 1866  
(Month) (Day) (Year)

7 AGE

49 yrs. 2 mos. 22 ds.  
If LESS than  
1 day, hrs.  
OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work. Vice President  
 (b) General nature of industry, business, or establishment in which employed (or employer) Arie Co. Electric Co

9 BIRTHPLACE  
(State or country)New York

10 NAME OF FATHER

Stephen Calvin Walker11 BIRTHPLACE OF FATHER  
(State or country)Massachusetts

12 MAIDEN NAME OF MOTHER

Isabella P. Lannan13 BIRTHPLACE OF MOTHER  
(State or country)Massachusetts

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Cornelia L. Phillips(Address) Chestertown Maryland

15

Filed Sept. 17, 1915 W. H. Hicks

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept 17

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

July 26, 1915, to Sept 17, 1915,that I last saw him alive on Sept 16, 1915,and that death occurred on the date stated above, at 8:35 a.m.

The CAUSE OF DEATH\* was as follows:

Acute dilatation of heart  
acute Inflammation  
of arteries sclerosis

Contributory Secondary (Duration) yrs. mos. ds.

(Signed) Frank B. Hines, M. D.(Address) Chestertown Md

(Duration) yrs. mos. ds.

(Signed) Frank B. Hines, M. D.(Address) Chestertown Md

(Duration) yrs. mos. ds.

(Signed) Frank B. Hines, M. D.(Address) Chestertown Md

(Duration) yrs. mos. ds.

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

Erie PaDATE OF BURIAL  
Sept. 19, 1915

20 UNDERTAKERS

J. E. Ferguson Chestertown Md

ADDRESS

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

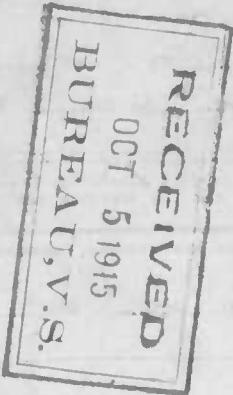
**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonacum*, etc., *Carcin-*

oma

"oma, Sarcoma, etc. of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 d.s.; *Bronchopneumonia* (secondary), 10 d.s. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railroad train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County..... New

15737

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 200

Village or City..... Mary

(No.)

150

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME..... Oscar Warwick Jr.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX..... Male

4 COLOR OR RACE..... Black

5 SINGLE,  
MARRIED,  
WIDOWED  
OR DIVORCED  
(Write the word)..... Separated

6 DATE OF BIRTH..... Sept. 24

(Month)

(Day)

(Year) 1905

7 AGE..... yrs. 1 mos. 1 ds.

If LESS than  
1 day, hrs.  
OR min.?

## 8 OCCUPATION..... Infant

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry business, or establishment in which employed (or employer).....

9 BIRTHPLACE  
(State or country)..... Mary, Ma

## PARENTS

## 10 NAME OF FATHER..... Oscar Warwick

11 BIRTHPLACE OF FATHER  
(State or country)..... Ma

## 12 MAIDEN NAME OF MOTHER..... Edna Harris

13 BIRTHPLACE OF MOTHER  
(State or country)..... Ma

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)..... Oscar Warwick

(Address)..... Mary, Ma

15 Filed 9-25-1915 Early A. Stofford

Deputy Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH..... Sept 25

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept. 24, 1915, to Sept. 25, 1915, that I last saw him alive on Sept. 24, 1915, and that death occurred on the date stated above, at 1 p.m.

The CAUSE OF DEATH \* was as follows:

Blue Baby

(Duration).... yrs. .... mos. .... ds.

Contributory  
Secondary

(Duration).... yrs. .... mos. .... ds.

(Signed)..... Dr. Munro Brin, M. D.

(Address)..... 1127 Wellington

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death .... yrs. .... mos. .... ds. In the State, .... yrs. .... mos. .... ds.

Where was disease contracted,  
if not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL..... At home

## DATE OF BURIAL..... Sept. 25, 1915

## 20 UNDERTAKER..... Father

## ADDRESS..... Mary, Ma

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, incun-

ges, *peritonacum*, etc., *Carcinoma*, *Sorecoto*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mumps*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchomemomia* (secondary), *10 ds.* Never report incipient symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

OCT 5 1915

BUREAU OF THE CENSUS

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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## 1 PLACE OF DEATH

County Kent

15738

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 203

Village or City

Eadesville Near Rock Hall

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

James Wesley Wicks

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

Black5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)Mariel

## 6 DATE OF BIRTH

No Rock Hall, 1857  
(Month) — (Day) (Year)

## 7 AGE

58 yrs. not known mos. ds. If LESS than  
1 day, hrs. OR min.?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

## 9 BIRTHPLACE

(State or country)

Kent Co Md

## PARENTS

## 10 NAME OF FATHER

Perry Wicks

## 11 BIRTHPLACE OF FATHER

(State or country)

Kent Co Md

## 12 MAIDEN NAME OF MOTHER

(State or country)

Felicity Jenkins

## 13 BIRTHPLACE OF MOTHER

(State or country)

Kent Co Md

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Eugene Thompson

(Address)

15

Filed 9/17 1915 T.B. Durding

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Sept 15, 1915  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from  
Sept 12, 1915, to Sept 15, 1915,that I last saw him alive on Sept 15, 1915,

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:

Pneumonia, labor 200

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed)

, M. D.  
William H. Keall

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death? At home

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

Sharpiron Cemetery Sept 17, 1915  
DATE OF BURIAL

## 20 UNDERTAKER

ADDRESS

Thos H. Casey of Rock Hall

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

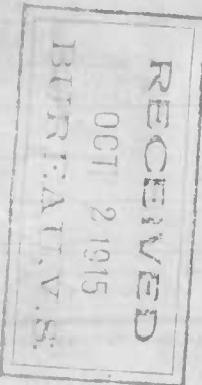
**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Houservt*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonacum*, etc., *Carcin-*

oma

*Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic varicose heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congentital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railroad train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scaphis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

**1 PLACE OF DEATH** **15739**

County **Saint**

Village or City near **Coleman** (No.)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. **211**

St. **Ward**)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

**2 FULL NAME**

**John Westley Wright**

## PERSONAL AND STATISTICAL PARTICULARS

<b>3 SEX</b>	<b>4 COLOR OR RACE</b>	<b>5 SINGLE, MARRIED, WIDOWED, OR DIVORCED</b> (Write the word)
<b>Male</b>	<b>Black</b>	<b>MARRIED</b>

<b>6 DATE OF BIRTH</b>	<b>Aug</b>	<b>5</b>	<b>, 1873</b>
	(Month)	(Day)	(Year)

<b>7 AGE</b>	<b>38</b>	<b>yrs. — mos. 3</b>	<b>ds.</b>	<b>If LESS than 1 day, ____ hrs. OR ____ min. ?</b>
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<b>8 OCCUPATION</b>	<b>Labors</b>
(a) Trade, profession, or particular kind of work	
(b) General nature of industry, business, or establishment in which employed (or employer)	<b>Farm work</b>

<b>9 BIRTHPLACE</b> (State or country)	<b>Saint Co Ind</b>
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<b>10 NAME OF FATHER</b>	<b>Philip Wright</b>
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<b>11 BIRTHPLACE OF FATHER</b> (State or country)	<b>Maryland</b>
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<b>12 MAIDEN NAME OF MOTHER</b>	<b>Mary Wilson</b>
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<b>13 BIRTHPLACE OF MOTHER</b> (State or country)	<b>Maryland</b>
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<b>14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE</b>	<b>Robert Wright</b>
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(Informant) **Robert Wright**  
(Address) **Bethelton Ind**

15 **Sept 11<sup>th</sup> 1916**  
Filed **William Parr**  
**Local REGISTRAR**

## MEDICAL CERTIFICATE OF DEATH

**16 DATE OF DEATH** **9<sup>th</sup> 7<sup>th</sup> 1915**  
(Month) (Day) (Year)

**17** I HEREBY CERTIFY, That I attended deceased from **June 6<sup>th</sup> 1915**, to **Sept 7<sup>th</sup> 1915**, that I last saw him alive on **Sept 7<sup>th</sup> 1915**,

and that death occurred on the date stated above, at **9<sup>th</sup> 7<sup>th</sup> 1915**.

The CAUSE OF DEATH\* was as follows:

**Chronic Valvular heart disease**

**and Bright's disease.**

(Duration) **1 yrs. 0 mos. 0 ds.**

Contributory  
(Secondary)

(Duration) **0 yrs. 0 mos. 0 ds.**

(Signed) **H. S. Maxwell**, M. D.

**9 11 1915**, (Address) **Still Pond Md**

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

**18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)**

At place of death **0 yrs. 0 mos. 0 ds.** In the State **0 yrs. 0 mos. 0 ds.**

Where was disease contracted, if not at place of death?

Former or usual residence

**19 PLACE OF BURIAL OR REMOVAL** **Coleman** **DATE OF BURIAL** **Sept 12 1915**

**20 UNDERTAKER** **W. H. Johnson** **ADDRESS** **Still Pond**

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death—Name, first, the disease causing death** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc.; *Carcinoma*, *Surcroma*, etc., of \_\_\_\_\_ (name origin); "Capillary" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic trivalvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

**RECEIVED**  
OCT 4 1915  
HOSPITALS